UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

SYMLIN (pramlintide)

Patient name:_____Medicaid or SS#_____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone #_____

All information to be legible, complete and correct or form will be returned

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FAX THE FOLLOWING INFORMATION FROM PROGRESS NOTES OR IN A LETTER OF MEDICAL NECESSITY

CRITERIA:

- Is being used for Type 1 or Type 2 adjunct therapy for patient who uses mealtime insulin
- Patient has failed desired glucose control despite optimal insulin therapy
- Patient does not have gastroparesis or hypoglycemia
- Is insulin compliant
- Does regular insulin monitoring
- Has HbA less than 9%
- Has not had a hypoglycemic incident requiring assistance in the past 6 months

AUTHORIZATION:

1 Year

RE-AUTHORIZATION:

Telephone call from pharmacy or doctor's office